STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: Essert Healthcare of Connecticut, Inc. of Sharon, CT d/b/a
Sharon Hospital
P.O. Box 789, 50 Hospital Hill Road
Sharon, CT 06069

CONSENT AGREEMENT

WHEREAS, Essert Healthcare of Connecticut, Inc. of Sharon, CT (hereinafter the "Licensee"), has been issued License No.0071 to operate a General Hospital known as Sharon Hospital, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced inspections on various dates commencing on March 11, 2008 and concluding on March 19, 2008; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated May 13, 2008 (Exhibit A – copy attached); and

WHEREAS, the Licensee has implemented changes in response to concerns expressed by the Department; and

WHEREAS, without admitting wrongdoing, the Licensee is willing to enter into this Consent Agreement and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Charles Therrien, its President and Chief Executive Officer, hereby stipulate and agree as follows:

1. The Facility shall contract with a credentialed Wound Care RN. The Certified Wound Care RN shall serve a minimum of sixteen (16) hours a week for a four (4) month period. The Certified Wound Care RN shall act and perform the duties assigned herein

at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.

2. The Department shall retain the authority to extend the period of the Certified Wound Care RN functions as required, should the Department determine that the Facility is not able to maintain substantial compliance with federal and state laws and regulations pertinent to pressure ulcers. Examples of violations which may cause the Department to invoke this provision include, but are not limited to, failure to notify the physician of a significant change in skin condition, and/or failure to provide care and treatment to patients identified with skin integrity issues and/or failure to implement physician orders. Determination of compliance with federal and state laws and regulations will be based upon findings.
3. The Certified Wound Care RN shall provide bi-weekly reports to the Department regarding his/her responsibilities and an assessment of the Facility's progress as related to issues of skin integrity.
4. Effective upon the execution of this Consent Agreement, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure:
    a. Patient assessments are performed in a timely manner and accurately reflect the condition of the patient;
    b. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
    c. Each patient's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care;
    d. Policies and procedures related to dehydration prevention be reviewed and revised to include, in part, notification of the attending physician or medical director when the patient's fluid intake does not meet their assessed needs;
    e. Patients with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;
    f. Necessary supervision and assistive devices are provided to prevent accidents;

g. Administration of medication include the assessments for, as necessary medications, pain management assessments and titration protocols; and

h. Practitioner orders for medication include the assessments for, as necessary medications, pain management assessments and titration protocols.

5. All physicians shall be responsible for examining their patients who have a potential for impaired skin integrity and shall document said assessments.

6. The Facility shall inservice nursing staff, physicians, pharmacists and other applicable licensed individuals regarding the policies and procedures pertinent to wound care.

7. Within fourteen (14) days of the execution of this Consent Agreement, the Facility shall ensure that a pharmacist review, on a weekly basis, one hundred percent (100%) of orders regarding IV medications which identify titration of medications for compliance with standards of practice and Facility policy and procedure. Such review shall continue for ninety (90) days following the execution of the Consent Agreement.

8. The Licensee shall establish a Quality Assurance Program (QAP) to review patient care issues including those identified in the May 13, 2008 violation letter. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors, and the Medical Director and other individuals as applicable. Minutes of the QAP meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department. The members of the QAP shall meet at least monthly to review and address the quality of care provided to patients and, if applicable, implement remediation measures.

9. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Agreement. The name of the designated individual shall be provided to the Department within said timeframe.

10. The Licensee shall pay a monetary penalty to the Department in the amount of four thousand dollars ($4,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Agreement. The money penalty and any reports required by this document shall be directed to:

Ann Marie Montemerlo, R.N.,
Supervising Nurse Consultant
Facility Licensing and Investigations Section,
Department of Public Health

11. All parties agree that this Consent Agreement is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Agreement or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above and any other administrative and judicial relief provided by law. This Consent Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
12. The terms of this Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
13. The Licensee understands that this Consent Agreement and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
14. The Licensee has had the opportunity to consult with an attorney regarding the contents of this document.

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WITNESS WHEREOF, the parties hereto have caused this Consent Agreement to be executed by their respective officers and officials, which Consent Agreement is to be effective as of the later of the two dates noted below.

Essert Healthcare of Connecticut of Sharon, CT

10/23/08
Date

By: _____
Charles Therrien, President

STATE OF Connecticut)

County of Litchfield) ss 10/23/08 2008

Personally appeared the above named Charles Therrien and made oath to the truth of the statements contained herein.

My Commission Expires: June 30, 2013
(If Notary Public)

Colleen A Leavitt

Notary Public [✓]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

10/24/08
Date

By: _____
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
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May 13, 2008

Charles Therrien, Administrator
Sharon Hospital
50 Hospital Hill Road, Po Box 789
Sharon, CT 06069

Dear Mr. Therrien:

Unannounced visits were made to Sharon Hospital that concluded on March 19, 2008 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing renewal inspection and to review for the implementation of a plan of correction for a violation letter dated 1/10/07.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits. Please respond with a plan of correction by May 28, 2008.

An office conference has been scheduled for June 4, 2008 at 10:00 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please address each violation with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Ann Marie Montemerlo, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

amm:jcf

c. Director of Nurses
Medical Dirctor

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D13 (b) Administration (2) and/or (c) Medical staff (4)(A) and/or (4) and/or (e) Nursing Service (1) and/or (i) General (6) and/or (l) Infection Control (1)(A).

1. During tour of the Operating Suite with the Director of the OR on 3/11/08, the following was observed:

a. Observation of the four (4) operating rooms on 3/11/08, identified plastic holders containing papers adhered to the walls and radios/CD players on tables, rendering those areas unable to be cleaned. Review of the facility policy for Cleaning/Sanitation within the Operating Suite identified that cleaning included damp dusting, spot cleaning of walls as needed and cleaning of all horizontal surfaces to ensure a clean environment.

b. In each operating room, patient transfer boards were observed propped against the wall with one end resting on the floor. During observation, a board was placed under the patient without wiping it down with a hospital approved disinfectant first.

2. Based on review of facility documentation, review of facility policy and interview with the facility personnel, the facility failed to ensure that biological spore testing was completed according to facility policy. The findings include:

a. Review of the documentation for the biological indicator testing on 3/11/08, for the 2 (two) Steris machines located in the OR, identified that although the machines internally completed diagnostic testing daily, the biological testing for spore presence was not completed since August 2007. Review of the facility policy for Quality Indicators for Sterilization Processing identified that biological spores, including the control, would be planted and incubated every week. During interview on 3/11/08, the Director of the OR stated she had no idea that the testing had not been completed.

b. Review of the biological indicator testing documentation for the steam sterilizers (#1, #2, #3) located in the OR, identified that although diagnostic, internalized and Bowie-Dick testing of each unit was completed on a daily basis, the biological indicator testing failed to be completed from 2/5/08 through 3/11/08. Review of facility policy for Proof Flash Biological Indicators reflected that biological indicator testing would be completed on a daily basis. For the steam sterilizer biologicals completed prior to February 5, 2008, documentation was lacking for the date that the indicators were removed from the incubator. Review of the policy for Quality Indicators for Sterilization Processing identified that although the indicators are checked after three (3) hours and intervals prior to the final reading, after forty-eight (48) hours the spore sample and control are removed from the incubator and the results are recorded in the biological indicator log book. Additionally, the steam sterilizer located in Central Sterile failed to have any results of biological indicator tests documented for the dates of 10/27/07, 1/2/08, 2/18/08 and 2/19/08.

c. Review of the gas sterilizer biological indicator log book on 3/11/08 identified that the standard for incubation time failed to be met according to manufacturer's recommendations

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on 5/11/07, 6/5/07, 10/2/07, 11/2/07, and 3/4/08 as evidenced by leaving the test spore in the incubator for less than the four (4) hour test time frame. Review of the log identified that on those days, the spore samples were read and recorded prior to the required four (4) hour incubation time. Review of the manufacturer's guidelines for use of the 3M Attest 1294 Rapid Readout EO Biological Indicator Profile identified that the test spore should be left in the incubator for four (4) hours before accepting the final negative biological indicator readout result. Additionally, on 6/6/07, 8/16-23/07 and 11/2/07, biological indicators were placed in the incubator, however, results of the test were not documented in the log book.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6).

3. Based on a tour of the facility, review of facility documentation and interview, the facility failed to secure/maintain one of two code carts on the Obstetrics (OB) unit. The findings include:

a. A tour of the OB unit was conducted on 3/11/08 with the Director of Maternity. Locked pediatric and adult code carts were located behind the nursing station and/or near the entranceway of the nursery. The adult code cart log identified that the cart was left unlocked from Sunday, March 9, 2008 to March 17, 2008. The carts lock was replaced on March 18, 2008. Interview with the Director of Maternity on 3/11/08 noted that night shift checks the code carts daily and that unit staff would notify the Central Sterile Department via a phone call when the cart needed to be checked/relocked. Review of the Code Cart Log identified that signatures represent that the code cart was checked for the following: code cart locked, defibrillator plugged in, patches attached. Review of the Code Cart Policy directed that the code cart must be checked daily and that the Materials Management staff was to be notified immediately after code carts are opened.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (h) Dietary Service (1) and/or (3) and/or (i) General (6).

4. Based on a tour of the dietary department, review of facility documentation, review of facility policy and interview, the facility failed to maintain temperature logs and/or acceptable food refrigeration temperatures. The findings include:

a. A tour of the dietary department was conducted on 3/13/08 with the Food Service Director. Dishwashing temperature logs were reviewed from June 1, 2007 to February 29, 2008. Documentation for dishwashing temperature monitoring was lacking for the breakfast meal on 8/15, 8/22, 9/2, 11/18, 11/22, 11/24, 12/14, 12/15, 12/18, 12/19, 12/24, 12/27/07 and 1/5, 1/9, 1/12, 1/25 through 1/27/08. Dishwashing temperature documentation was lacking for the noon meal on 6/28, 8/28, 8/29, 9/2, 9/5, 11/2, 11/7, 11/8, 11/22, 11/23, 12/5, 12/6, 12/12 through 12/15, 12/19/07 and 1/5, 1/9, 1/26 1/27/08. Documented monitoring of the dishwashing temperatures was lacking for 7/6, 7/9, 7/16, 8/28, 9/2, 9/4 through 9/6, 9/10, 9/12, 9/18, 9/25,

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

9/27, 9/28, 11/7, 11/8, 11/17, 11/18, 12/9, 12/11, 12/13 through 12/17, 12/24, 12/30, and 12/31/07. Review of the facility dishwashing temperature log directed staff to document a wash and rinse temperature for each meal daily.

b. Refrigerator/freezer temperature logs from 1/14/08 to 3/3/08 were reviewed on 3/13/08 with the Food Service Director. Refrigerator temperatures that included the tray line and/or 4- door refrigerators and/or the walk in and/or milk coolers were documented as being above 40 degrees Fahrenheit on 2/9, and 2/11 through 2/17/08 for the morning and/or evening shift. Interview with the Food Service Director on 3/13/08 noted that when the refrigerator temperatures are above 40 degrees Fahrenheit, dietary staff recheck the temperature and notify "Operations " if necessary. The facility was unable to provide documentation that refrigerator temperatures had been rechecked and/or that Operations Management had been notified when the temperatures exceeded 40 degrees Fahrenheit. Although the refrigerator temperature logs noted that an acceptable refrigerator temperature had to be less than 40 degrees Fahrenheit, the facility dietary infection control policy indicated that 40 degrees Fahrenheit or below was an acceptable refrigerator temperature.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration and/or (f) Diagnostic and therapeutic facilities and/or (i) General (6).

5. Based on review of hospital policy, observation, and interview, the facility failed to sanitize equipment according to manufacture's recommendations. The findings include:

a. A tour of the Rehabilitation (Rehab) Department was conducted on 3/18/08 with the Rehab Director. Hydro Track equipment contained water and an area that housed the water filter. The Hydro Track maintenance log directed that the Hydro Track would be cleaned every week or every other week depending on usage. The log also reflected that the Hydro Track was cleaned last on 2/28/08. Review of the log with the Rehab Director on 3/18/08 noted that the Hydro Track should have been cleaned on 3/6/08 and/or 3/13/08 depending on usage history. Interview with the Rehab Aide identified that the Hydro Track was cleaned by emptying the water and sanitizing the inside tub. According to the manufactures recommendations the skimmer basket should be cleaned weekly. Documentation of skimmer basket cleaning according to manufacturer's recommendations could not be provided.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (d) Medical records (7).

6. Based on medical record review, review of facility policy and interview, the facility failed to complete discharge summaries for four (4) of sixteen (16) patients reviewed (Patient's #27, 28, 29 and 30) who were discharged according to facility policy. The findings include:

a. A tour of the Medical Record department was conducted with the Director of Medical Records on 3/18/08. The incomplete medical record log dated 3/17/08 identified that four of sixteen

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patient records lacked a dictated and/or transcribed discharge summary. Patient #27 was discharged on 2/10/08. The patient's medical record lacked a discharge summary. Review of the medical record log dated 3/17/08 noted that 36 days had elapsed since the patient was discharged from the hospital.

b. Patient #28 was discharged on 2/2/08. The patient's medical record lacked a discharge summary. Review of the medical record log dated 3/17/08 identified that 45 days had elapsed since the patient was discharged from the hospital.

c. Patient #29 was discharged on 1/27/08. The patient's medical record lacked a discharge summary. Review of the medical record log dated 3/17/08 identified that 50 days had elapsed since the patient was discharged from the hospital.

d. Patient #30 was discharged on 1/19/08. The patient's medical record lacked a discharge summary. Interview with the Director of Medical Records on 3/18/08 indicated that physicians are notified in advance of records that need to be completed on a weekly basis and each week a delinquent medical record list is generated. Interview with the Medical Staff Coordinator on 3/18/08 identified that a physician whose record was not completed within 30 days was placed on suspension. Due to a recent staff leave of absence in the medical record department, physician suspensions for MD #1, MD #2 and MD #3 did not occur timely. Review of the medical record log dated 3/17/08 identified that 58 days had elapsed since Patient #30 was discharged from the hospital. Review of the facility policy for medical record completion identified that a medical record would be deemed delinquent, in part, if the discharge summary was not present and authenticated within 14 days of discharge and that a physician would be placed on suspension for any delinquent medical record 30 days old.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D13 (b) Administration (1)(A) and/or (C) Medical Staff (2)(B).

7. Based on review of Patient #5's medical record and review of the Medical Staff Bylaw Rules and Regulations, the facility failed to ensure that the physician wrote a post-operative note. The findings include:

a. Patient #5 underwent a left nasal lacrimal probing and a left therapeutic turbinate fracture on 3/11/08. Review of the medical record failed to identify an immediate post-operative note. Review of the Medical Staff Bylaw Rules and Regulations identified that the operative note was the responsibility of the attending surgeon but the Bylaws failed to identify a time frame in which for the immediate postoperative note was to be written.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (d) Medical records (3) and/or (i) General (6).

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8. Based on medical record review and interview for two (2) of two (2) sampled patients who received respiratory treatments (Patient's #46 and 47), the facility failed to ensure that the respiratory medication orders were complete. The finding includes:

a. Patient #46 had a diagnosis of chronic obstructive pulmonary disease with exacerbation. Physician orders dated 3/18/08 directed Albuteral nebulizer every four hours while awake and as needed at night. The order failed to prescribe the dosage of the medication.
b. Patient #47 had a diagnosis of influenza. The physician order dated 3/17/08 directed Albuterol/Atrovent nebulizer every four hours while awake. The order failed to prescribe the dosages of the medications. Interview with the Pulmonologist on 3/19/08 at 10:30 AM noted that the hospital stocked only one dosage of Albuterol and that there was no room for error. According to the hospital medical staff bylaws, the attending physician would be responsible for the preparation of a complete and legible medical record for each patient.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

* 9. Based on medical record review of patient skin assessments (Braden Scale), review of facility policy and interview, the facility failed to complete accurate skin assessments for Patient's #12, 13, 14, 17, 21, 37, 38 and 39 as per facility policy. The findings include:

a. Patient #12 was 83 years old and had a Braden Scale assessment dated 3/12/08 that identified that the patient was at "moderate risk" for developing skin integrity problems. Patient #37 was 86 years old and had a Braden Scale assessment dated 3/11/08 that identified that the patient was "at risk" for the development of skin integrity problems. Patient #38 was admitted with substance abuse and seizures and had hemodynamic instability. The Braden Scale assessment dated 3/9/08 identified that the patient was "at risk" for the development of skin integrity problems. Although the assessments noted the presence of other risk factors, the patients' skin risk was not advanced to the next level as per policy. Subsequently, Patient's #12, 37 and 38 were inaccurately assessed to be at a lower risk level for the development of skin integrity problems.
b. Patient #13 was 83 years old and was diagnosed with a left hip fracture on 3/8/08. The initial Braden Scale skin assessment dated 3/8/08 identified that the patient was "at risk" for skin integrity problems. The Braden Scale assessment failed to note that the patient had other risk factors (advanced age) and therefore the patient's risk score would have increased to "moderate risk".
c. Patient #14 was 81 years old and had a Braden Scale assessment dated 3/10/08 that identified that the patient was "at risk" for the development of skin integrity problems. Although the patient was of advanced age, the assessment indicated no other risk factors were present. Subsequently, the patient was inaccurately assessed to be "at risk" instead of at "moderate risk" for the development of skin integrity problems in accordance with facility policy.
d. Patient #17 was admitted to the Senior Behavioral health Unit on 3/8/08 with diagnoses that included Dementia with Behavioral disturbance. Review of the admission nursing assessment

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dated 3/8/08 inaccurately identified that the patient was at low risk (score was 16) for the development of pressure ulcers when review of the Braden skin risk assessment directed staff to advance the patient's risk score to the next level if the patient had additional risk factors including advanced age. Review of the clinical record identified that the patient was 85 years old and should have been identified as a moderate risk for the development of pressure ulcers (score 13-14).

e. Patient #21 (99 year old) was admitted to the hospital's Intensive Care Unit (ICU) on 3/12/08 at 4:45 am with diagnoses that included sepsis, hypotension, urinary tract infection and a history of dementia. Review of RN #1's admission assessment dated 3/12/08 at 5:23 am identified that the patient was lethargic, weak, incontinent, had intact skin with a Braden skin assessment score of twenty (20) points which indicated the patient was not at risk for the development of pressure ulcers (at risk 18 or less). Review of the Braden skin assessment with RN #2 (on 3/12/08) identified that the assessment was inaccurate in that the patient's actual status was not reflective in the assessment. RN #2 identified that the patient was on bedrest, had an order for clear liquids, was incontinent of stool, and had altered skin integrity, all factors that would decrease the total Braden score making the patient at high risk for the development of pressure ulcers. Additionally, the Braden skin risk assessment directed staff to advance the patient's risk score to the next level if the patient had additional risk factors including hemodynamic instability and advanced age. RN #2 reassessed the patient and identified that the Braden score was twelve (12) indicating that the patient was at high risk for the development of pressure ulcers. Interview with RN #2 identified that since the initial Braden didn't reflect that the patient was at risk for the development of pressure ulcers, a care plan was not generated. Observation of the patient's skin with RN #2 on 3/12/08 at 11:00 am identified a deep purple area on the right heel that was asymmetrical and measured 3.5 centimeters (cm) by 2.25 cm by 2 cm by 1 cm. Although review of facility documentation identified that RN #1 was educated regarding Braden skin assessments in 11/06, RN #1 failed to accurately assess Patient #21's skin including a Braden skin assessment upon admission to the ICU on 3/12/08.

f. Patient #39 was admitted to the hospital with a diagnosis of dehydration with fever of unknown origin and had hemodynamic instability. The Braden Scale assessment dated 3/11/08 identified that the patient was "at risk" for the development of skin integrity problems. The assessment failed to reflect that the patient had hemodynamic instability and/or fever as an additional risk factor, and subsequently the patient was inaccurately assessed to be at a lower risk level for the development of skin integrity problems.

Interview with the Chief Nursing Officer on 3/12/08 at 1:30 PM noted that the computerized initial skin risk assessment (Braden Scale) does not prompt the nurse to identify additional risk factors and therefore this was not done per policy. The hospital considered advanced age to be a patient who was at least 80 years old. Review of the facility policy for Skin Integrity Standard identified four levels of skin risk (at risk, moderate risk, high risk, very high risk). If a patient was assessed at risk or at moderate risk on the Braden Scale Stratification, and other risk factors were present (advanced age, fever, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability) they were to advance to the next skin risk level.

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The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (3) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (g) Pharmacy (1) and/or (i) General (6).

* 10. Based on review of the medical record, interview with facility personnel and review of facility policy, the facility failed to ensure that a comprehensive care plan was completed for Patient #13 and/or that the caregiver was aware of the patient's level of assistance. The findings include:

a. Patient #13 was 83 years old and was admitted on 3/4/08 with diagnoses that included depression r/o dementia, Parkinson's disease, atrial fibrillation, muscle weakness and status post femoral artery embolectomy and kyphoplasty in January 2008. The patient was known to have a history of falls and the Nursing Assessment dated 3/4/08 identified that the patient was a high fall risk and required a walker when ambulating. Review of a skills group note dated 3/5/08 identified that Patient #13 lacked safety awareness and required a supervised environment. A Physical Therapy Screen completed on 3/6/08 identified that the patient's unsupported standing balance was poor and that a contact guard was required for assistance when the patient went from sitting to standing. Review of the Multidisciplinary Care Plan (MTP) dated 3/5/08, failed to identify the patient's lack of safety awareness and that the patient required continual assistance during activities of daily living (ADLs) including a contact guard when transitioning from sitting to standing. On 3/8/08 at approximately 7:15 AM, Mental Health Worker #1 was assisting Patient #13 with ADLs as the patient sat on the edge of the bed. Mental Health Worker #1 turned away from Patient #13 as the worker went to the hallway to retrieve linen. Upon Mental Health Worker #1's return, Patient #13 was found at the bedside, kneeling on the right knee. Patient #13 was diagnosed with a fracture of the left hip. During interviews with the Director and Manager of Senior Behavioral Health on 3/17/08, they identified that Mental Health Worker #1 should never have left the patient alone. Review of Mental Health Worker #1's orientation paperwork, job description and re-education documentation failed to reflect specific training regarding remaining in constant assistance during ADLs for the patient under supervised care. Although the facility policies for Orientation of New Employees and Assigning Patient Care identify routine assignments shared by staff members and orientation of all staff members to categories of skill lists, specific parameters for the patient who required supervision during ADLs was not addressed.

Review of the patient's plan of care dated 3/8/08 directed positioning/repositioning but failed to direct the frequency. An intervention for heel protection was initiated on 3/10/08, two days after the patient was identified to be at increased risk for skin integrity problems. According to the facility skin integrity standard policy, patients identified at risk for skin integrity problems required frequent turning, heel protection, and management of friction/sheer.

In addition, Patient #13 had a surgical repair of the left hip fracture on 3/10/08. The Braden scale skin assessments dated 3/10/08 and 3/12/08 identified that the patient was at high risk for developing skin integrity problems. The plan of care dated 3/10/08 through 3/12/08 directed positioning/repositioning, an air mattress and heel protectors. Observation on 3/12/08 at 9:45 AM, identified Patient #13 in the bed with an air mattress and lambs wool devices on their heels. Redness of the patient's right heel was noted. Interview with NA #2 on 3/12/08 at 11 AM, indicated

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that the patient's right heel was also "a little red" on 3/11/08. Although the patient had lambs wool devices to the heels, the facility could not provide documentation that the heel devices provided pressure reduction and/or relief. The patient's plan of care failed to be revised once the redness was noted. Subsequently, the patient received gel heel pressure reduction devices on 3/13/08.
In addition, Patient #13's initial nursing assessment on 3/8/08 identified that the patient's abdomen was soft and non- tender. Information regarding the patient's last bowel movement (BM) was not entered. The plan of care dated 3/8/08 indicated a problem of constipation. The patient had a surgical repair of the left hip fracture on 3/10/08. Physician orders dated 3/10/08 directed Milk of Magnesia daily and a Dulcolox suppository as needed. The nursing shift assessment dated 3/11/08 noted that the patient last had a BM on 3/7/08 and that the abdomen was soft, non- distended and bowel sounds were present. A nursing shift assessment dated 3/11/08 at 11:45 PM identified that the patient's bowel assessment was abnormal; the patient had not had a BM in 4 days and that it would be reported to the next shift to give a suppository. The nursing assessment dated 3/12/08 at 8 AM, documented that the patient's stool pattern was abnormal and inaccurately documented that the patient had not had a BM in 4 days (last BM 5 days ago on 3/7/08). The assessment further documented that it would be reported to the next shift to give a suppository. Review of the March 2008 Medication Administration Record (MAR) identified that the patient received the Dulcolox suppository after 5 days without a BM on 3/12/08 at 2:30 PM. Nursing narratives dated 3/12/08 at 2:45 PM, noted that firm stool was present in the patient's rectal cavity. The nursing shift assessment dated 3/13/08 at 12 AM indicated that the patient had one tiny hard BM on the previous shift. Interview with RN #5 on 3/12/08 at 11:40 AM identified that as needed medications for constipation were usually administered when the patient has had no BM in the past 3 days.
Interview with the Chief Nursing Officer on 3/18/08 at 2:20 PM noted that the hospital did not have a policy to direct the initiation/administration of as needed laxative medications.
In addition, the initial nursing assessment identified that the patient had pain with movement. The care plan dated 3/8/08 directed to assess and treat pain. Patient #13 had a surgical repair of the left hip fracture on 3/10/08. The MAR identified that the on 3/11/08, the patient received Tylenol as ordered at 1:30 PM. A physical therapy evaluation dated 3/11/08 at 5:04 PM, noted that the patient had pain when the left lower extremity was moved. The MAR identified that the patient received Dilaudid 0.25 milligrams (mg) as ordered on 3/11/08 at 8:35 PM. Nursing documentation dated 3/12/08 at 8 AM, indicated that the patient had no pain at rest. Observation on 3/12/08 at 10 AM, identified that the patient cried loudly when repositioned. Interview with RN #6 on 3/12/08 at 10:10 AM noted that she hated to give Patient #13 too much medication because of her cognition. Interview with NA #2 on 3/12/08 indicated that the patient also cried on 3/11/08 when repositioned. Review of the patient's clinical record with the Chief Nursing officer on 3/12/08 at 1:15 PM identified that the patient was repositioned at least every two hours. Although the patient was identified to have pain with repositioning the patient did not receive pain medication for approximately 13.5 hours (from 8:35 AM on 3/11/08 to 10:10 AM on 3/12/08).

The following are sviolation of the Connecticut General Statutes Section 46a-152 (d)(2) and/or 46a-153 and/or the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (1) (A) and/or (2) and/or (c) Medical staff (2)(B) and/or (d) Medical records (3) and/or (e) Nursing service (1)

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and/or (i) General (6).

11. Based on medical record review, review of facility policy and interview for two (2) of three (3) patients reviewed who were restrained (Patient's #9 and 10), the facility failed to apply restraints per the physician's order. The findings include:

a. Patient #9 was admitted to the Emergency Department (ED) on 2/3/08 with a diagnosis of respiratory failure. The physician order dated 2/3/08 directed the use of bilateral wrist restraints to prevent the patient from dislodging the endotracheal tube. ED nursing documentation dated 2/3/08 at 1:30 AM identified that the patient was placed in soft hand mitt restraints and the physician signed the order. Review of the ED Ventilator Admission orders failed to direct the use of the hand mitt restraints. Interview with the Director of the ED on 3/11/08 noted that both mitt restraints and soft limb restraints were utilized by the facility.
b. Patient #10 was admitted to the ED on 1/12/08 with diagnoses that included intoxication. The physician order dated 1/12/08 noted that the patient was a danger to self and directed the use of 2 side rails as a restraint. ED nursing documentation dated 1/12/08 at 1:30 PM noted that the patient would not stay on the stretcher and was placed in four- point restraints. Review of the patient's record on 3/11/08 failed to identify physician order for the use of the four- point restraints. The facility restraint policy identified that the registered nurse may initiate a restraint. A verbal or written order must be obtained within 4 hours if the restraint was a "behavioral restraint" and within 12 hours if the restraint was a "medical restraint".

12. Based on review facility documentation, facility policy and interview, the facility failed to maintain an accurate restraint log in the Emergency Department. The findings include:

a. Patient #9 was admitted to the Emergency Department (ED) on 2/3/08 with a diagnosis of respiratory failure. ED nursing documentation dated 2/3/08 at 1:30 AM identified that the patient was placed in soft hand mitt restraints. The February 2008 restraint log indicated "soft" for the type of restraint used and failed to denote the number of restraints used and/or whether soft limb or mitt restraints were used. Although the restraint log noted that the patient was intubated, the log failed to reflect the specific behavior requiring restraint use to include 'pulling tubes". Interview with the Director of the ED on 3/11/08 noted that both mitt restraints and soft limb restraints were utilized by the facility and the specific behavior that required restraint use must be documented on the log.
b. Patient #10 was admitted to the Ed on 1/12/08 with diagnoses that included intoxication. The restraint flow sheet identified that the patient was placed in restraints at 1:15 PM on 1/12/08. The box on the restraint log to indicate the specific behavior requiring the restraint only identified "yes" and failed to note the specific behavior exhibited by the patient and/or the type of restraint used. Restraint log documentation identified that the patient's restraints were discontinued at some point and then restarted, yet failed to document when this occurred and/or the behavior that required the restraints to be reapplied. The hospital restraint policy identified that data collection (restraint log) for performance improvement included the start and end times

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of each episode of restraint or seclusion and the type of restraint used.
The facility restraint flow sheet was reviewed with the Director of the ED on 3/19/08 at 1:30 PM. The restraint flow sheet identified three limb release codes and did not include a code for the fourth limb release. The flow record noted "RU"= right upper limb, "RL"= right lower limb and incorrectly noted "LU" as left upper limb. The restraint flow sheet and/or restraint policy did not direct staff on how often to release a restrained limb.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (3) and/or (e) Nursing service (1) and/or (i) General (6).

* 13. Based on a review of clinical records, review of policies, review of facility documentation and staff interviews, the hospital failed to ensure for Patient's #15, 16 and 18, that the attending physician was notified when the patients were unable to consume the identified estimated daily fluid requirements and/or that dehydration assessments were conducted and/or that intake and output monitoring was accurate and/or complete as per facility policy. The findings include:

a. Patient #15 was admitted to the Senior Behavioral Unit on 3/5/08 with diagnoses that included dementia with behavioral disturbance. Review of the clinical record dated 3/8/08 identified that the patient had two (2) episodes of vomiting at 1:30 pm and 6:00pm with intake and output (I&O) monitoring initiated on 3/9/08. Review of the intake and output records during the period of 3/9/08 through 3/12/08 identified that although the patient utilized the bathroom, staff failed to measure the patient's urinary output in accordance with the hospital's policy. The I&O policy directed staff to measure urinary output utilizing a measuring device to insure adequate assessment and management of the patient. In addition, review of the I&O records dated 3/10/08 and 3/11/08 failed to reflect that the patient's end of shift urinary output and/or total 24-hour output was recorded in accordance with the I&O policy. Review of the policy identified that the patient's I&O is evaluated daily to determine adequacy.

Review of the clinical record with the Nurse Manager identified that based upon the patient's weight, the patient required 1,759 cubic centimeters (cc) of fluid daily to maintain hydration. Review of the intake and output (I&O) record identified that although the patient had not met the daily fluid requirements on three of the four days (3/9, 3/11 and 3/12/08), staff failed to perform comprehensive dehydration assessments in accordance with hospital policy. Although the Dehydration Risk Assessment policy didn't specify the frequency in which nursing should perform dehydration assessments, review of I&O flow record directed staff to perform dehydration assessments every four (4) hours inclusive of vital signs, skin turgor and mucous membranes.

In addition, although staff failed to perform consistent and/or thorough dehydration assessments when Patient #15 failed to meet the daily fluid goal, review of the Change in Condition policy directed that the attending physician be notified when a patient consumes less than 1,200 ccs of fluid in a 24-hour period. Review of the clinical record indicated that although the patient

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consumed less than 1,200 ccs in 24-hours on 3/11/08 and 3/12/08, staff failed to notify the physician of the patient's decreased fluid intake.

b. Patient #16 was admitted to the Senior Behavioral Unit on 2/27/08 with diagnoses that included dementia with behavioral disturbance. Review of the clinical record dated 2/28/08 identified that the patient was diagnosed with a urinary tract infection with a plan of care that included I&O monitoring. Review of the intake and output records during the period of 2/28/08 through 3/12/08 identified that although the patient utilized the bathroom, staff failed to measure the patient's urinary output in accordance with the hospital's policy. In addition, review of the I&O records dated 3/2/08, 3/6/08, 3/7/08 and 3/8/08 failed to reflect that the patient's end of shift urinary output and/or total 24-hour output was recorded in accordance with the I&O policy.

Review of the clinical record with the Nurse Manager identified that based upon the patient's weight, the patient required 2,181 cc's of fluid daily to maintain hydration. Review of the I&O record identified that although the patient had not met the daily fluid requirements on thirteen (13) of the 13 days (2/28/08 through 3/11/08), staff failed to perform comprehensive dehydration assessments in accordance with hospital policy. In addition, although the plan of care directed hydration assessments be performed every shift, review of the flow record directed that hydration assessments be performed every four (4) hours, a discrepancy in the plan of care. Interview with the Nurse Manager stated that hydration assessments should be performed every 4 hours when a patient is on I&O and that staff were previously educated regarding this expectation.

In addition, although staff failed to perform consistent and/or thorough dehydration assessments when Patient #16 failed to meet the daily fluid goal, staff failed to notify the attending physician of the patient's inability to consume at least 1200 cc's of fluid in a 24-hour period in accordance with the hospital's policy on 2/28/08, 3/4/08, 3/10/08 and 3/11/08.

c. Patient #18 was admitted to the Senior Behavioral Unit on 3/5/08 with diagnoses that included dementia with depression. Review of the clinical record dated 3/8/08 identified that the patient was diagnosed with Clostridium Difficile (C-Diff) infection with a plan of care that included I&O monitoring. Review of the intake and output records during the period of 3/8/08 through 3/11/08 identified that although the patient utilized the bathroom at times, staff failed to measure the patient's urinary output in accordance with the hospital's policy. In addition, review of the I&O records dated 3/8/08, 3/10/08, and 3/11/08 failed to reflect that the patient's end of shift urinary output and/or total 24-hour output was recorded in accordance with the I&O policy. Interview with the Nurse Manager identified that although staff received education regarding I&O monitoring in 12/06 and during the period of 1/23/08-3/4/08, staff were inconsistently compliant with the hospital's policy.

Review of the clinical record with the Nurse Manager identified that staff calculated that the

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patient required 1,800 ccs of fluid in 24-hours to maintain hydration. Review of the I&O records during the period of 3/8/08 through 3/11/08 failed to identify that the patient met the daily fluid requirements on all four (4) days, failed to perform comprehensive dehydration assessments in accordance with hospital and/or notify the attending physician when the patient consumed 920 ccs of fluid on 3/8/08 and 1,080 ccs on 3/9/08 in accordance with the Change in Condition policy. On 3/12/08, the Patient #18 was admitted to the hospital's medical unit for intravenous hydration and treatment of thrush.

Review of facility documentation and interview with the Nurse Manager on 3/13/08 identified that although staff received education regarding I&O, dehydration assessments, change in condition, and physician notification policies in 12/06 and during the period of 1/23/08-3/4/08, staff were inconsistently compliant with following hospital policies.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records and/or (e) Nursing service (1) and/or (i) General (6).

* 14. Based on a review of clinical records, review of policies, and staff interviews, the hospital failed to initiate and/or revise and/or ensure the plan of care was comprehensive for Patient's #14, 15, 16, 17, 18, 37, 38 and 39. The findings include the following:

a. Patient #14 was 81 years old and had a diagnosis of pneumonia. The Braden Scale assessment dated 3/10/08 identified that the patient was "at risk" for altered skin integrity and mobility was slightly limited. The Braden Scale assessment dated 3/12/08 identified that the patient was "moderate risk" for altered skin integrity and mobility was slightly limited. The plan of care in place from 3/10/08 to 3/12/08 noted that the patient had a risk for altered skin integrity and directed to assess and reassess skin. The plan of care failed to identify specific interventions to prevent alterations in skin integrity. The patient was observation on 3/12/08 at 10:30 AM in the bed with a pressure reduction mattress and without the benefit of heel protection/heel pressure relief. On 3/12/08 at 1:15 PM, the patient was observed in the chair, sitting on an incontinent pad and without the benefit of an anti- pressure device. According to facility policy if a patient was assessed "at risk" or moderate risk" on the Braden Skin assessment, interventions included frequent and/or every two hour positioning, pressure reduction support surfaces (bed and chair), and heel protection

b. Patient #15 was admitted to the Senior Behavioral Unit on 3/5/08 with diagnoses that included dementia with behavioral disturbance. Review of the clinical record dated 3/8/08 identified that the patient vomited at 1:30 pm and 6:00 pm and was unable to consume dinner. Review of the clinical record with the Nurse Manager identified that although the physician was notified of the change in condition, a treatment plan to address the patient's vomiting was not developed until the following day (3/9/08 at 7:00 am). Further review of the clinical record identified that the patient required 1,759 cubic centimeters (cc) of fluid daily to maintain

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hydration. Review of the I&O records identified that although the patient had not met the daily fluid requirements on three of the four days (3/9, 3/11 and 3/12/08) an individualized treatment plan was not developed to address this issue. Interview with the Nurse Manager (on 3/13/08) identified that the treatment plan should have been revised when the patient had episodes of vomiting on 3/8/08 and when the patient was unable to meet the estimated fluid goals in accordance with the hospital's policy.

Review of the admission nursing assessment dated 3/5/08 reflected that LPN #1 completed the initial skin assessment and noted that the patient's buttocks was reddened. Review of the clinical record during the period of 3/5/08 through 3/11/08 identified that the patient was confused, required assistance with activities of daily living (ADL's) and transfers, and had episodes of urinary incontinence. Review of the daily flow records during the same period of time indicated that the Patient's buttocks remained unchanged (reddened) when compared to the admission assessment. On 3/11/08 at 2:40 pm the Patient was observed to require maximal assistance for transfers and toileting, was observed to be seated in a wheelchair without the benefit of a pressure-relieving device from 10:45 am to 2:40 pm, and during care was observed with a reddened buttocks. Review of the Patient's treatment plan with the Nurse Manager failed to address the Patient's alteration in skin integrity and/or develop preventative interventions in accordance with the hospital's policy. Review of the Skin Integrity policy identified that patient's at risk for the development of pressure ulcers be turned every-two (2) hours, use pillows for positioning, pressure reduction support surfaces, maximal remobilization, protect heels and manage moisture, nutrition, friction, and shear. Subsequent to surveyor inquiry, the Nurse Manager evaluated the Patient, documented the presence of a stage-one (1) pressure ulcer located on the gluteus and implemented a treatment plan and addressed the alteration in skin integrity.

c. Patient #16, a patient on the Senior Behavioral Health Unit, had diagnoses that included dementia with behavioral disturbance and was diagnosed with a urinary tract infection on 2/28/08 and had a plan of care that directed I&O monitoring and hydration assessments each shift. Review of the clinical record with the Nurse Manager identified that based upon the patient's weight, the patient required 2,181 ccs of fluid daily to maintain hydration. Review of I&O records identified that although the patient had not met the daily fluid requirements on thirteen (13) of the 13 days (2/28/08 through 3/11/08, staff failed to revise the treatment plan to address this issue.

Review of the admission nursing assessment dated 2/27/08 identified that the patient was severely confused and required assistance with mobility and ADL's. The initial Braden skin assessment identified that the patient scored thirteen (13) points indicating that the patient was at moderate risk for the development of pressure ulcers. Review of the clinical record during the period of 2/28/08 through 3/11/08 identified that the patient continued to require assistance with ADL's and transfers, had episodes of urinary incontinence and was confused. On 3/11/08 at 2:30 pm during observation of care, the patient required maximum assistance with transfers and toileting, was observed seated in a wheelchair without the benefit of a pressure-relieving device from 10:40 am to 2:30 pm, and during care was noted by the surveyor to have a reddened

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buttocks. Review of the clinical record with the Nurse Manager identified that a treatment plan should have been initiated upon admission (2/27/08) when the patient was determined to be at risk for the development of pressure ulcers, however, staff failed to initiate a plan of care in accordance with the hospital's policy. Subsequent to surveyor inquiry on 3/11/08, the Nurse Manager initiated a treatment plan to address the Patient's impaired skin integrity.

d. Patient #17, a Patient on the Senior Behavioral Health Unit, was admitted to the hospital on 3/8/08 with diagnoses that included Dementia with Behavioral disturbance. Review of the admission nursing assessment dated 3/8/08 with the Nurse Manager identified that although the RN noted the patient was at low risk (16 points) for the development of pressure ulcers, this assessment was inaccurate in that additional risk factors, such as advanced age, was not taken into consideration as directed by the hospital's policy. Review of the clinical record during the period of 3/8/08 through 3/11/08 identified that the patient was confused, required assistance with ADL's and transfers. During observations on 3/11/08, the Patient was seated in a wheelchair without the benefit of a pressure-relieving device from 10:20 am to 1:45 pm. At 1:45 pm, the patient was transferred to the toilet with maximum assistance and observed to be wearing an incontinent brief saturated with urine. Observation of the Patient's skin on 3/11/08 at 2:00 pm with RN #3 and the Nurse Manager identified that the Patient had developed multiple stage-one pressure ulcers not previously identified in the clinical record. Although the Patient presented with risk factors for the development of pressure ulcers, the hospital failed to institute a plan of care to prevent pressure ulcers from developing. Subsequent to surveyor inquiry on 3/11/08, the Nurse Manager initiated a treatment plan to address the Patient's impaired skin integrity.

e. Patient #18, a patient on the Senior Behavioral Health Unit, had diagnoses that included dementia with depression and was diagnosed with a C-Diff infection on 3/8/08 with I&O monitoring initiated. Review of the clinical record with the Nurse Manager identified that the patient required 1,800 cc's daily to maintain hydration. Review of I&O records during the period of 3/8/08 through 3/11/08 identified that although the patient had not met the daily fluid requirements on four (4) of the 4 days, staff failed to revise the treatment plan to address this issue. Review of the Treatment Planning Policy identified that each patient would have an individualized and comprehensive plan based on an inventory of the patient's strengths and limitations and is revised as indicated.
Review of the admission Braden skin assessment dated 3/5/08 identified that the Patient scored twelve (12) points indicating that the Patient was at high risk for the development of pressure ulcers. Review of the clinical record during the period of 3/5/08 through 3/11/08 identified that the patient was confused, required assistance with ADL's and transfers, was incontinent of bowel and bladder and diagnosed with a C-Diff infection on 3/8/08. On 3/11/08 at 11:30 am, the Patient was transferred to bed for care and observed with a reddened coccyx. The Patient was subsequently transferred back into the recliner chair at 11:45 am without the benefit of a pressure-relieving device. Further observation of the Patient at 1:20 pm identified that the patient remained in the recliner chair without a pressure-relieving cushion. At 1:20 pm, the

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Patient was transferred back to bed, noted to be incontinent of a medium loose stool and the Patient's coccyx and heels were reddened. Although the Patient utilized a Comfortline mattress (pressure-relief), the hospital failed to institute a treatment plan when the Patient was identified to be at risk for the development of pressure ulcers. Subsequent to surveyor inquiry on 3/11/08, the Nurse Manager assessed the Patient and documented the presence of a stage-one pressure ulcer on the Patient's coccyx and bilateral heels with a treatment plan developed to address the Patient's alteration in skin integrity.

f. Patient's #37, 38 and 39 were assessed to have a level of risk for developing skin integrity problems. Although the plan of care for these patients identified the risk for altered skin integrity and that the patients needed to be repositioned, the care plans lacked specific patient interventions and turning schedules to prevent skin integrity problems. According to facility policy if a patient was assessed at a level of risk for altered skin integrity, interventions included frequent and/or every two hour and/or increased repositioning, pressure reduction support surfaces (bed and chair), and heel protection.

Review of facility documentation and interview with the Nurse Manager identified that treatment plans should have been initiated when patient's were determined to be at risk for pressure ulcer development in accordance with the hospital's policy and although staff were provided education regarding the hospital's Master Treatment Plan policy in 12/06, staff were inconsistently compliant with implementation of that policy.

* 15. Based on review of the medical record, interview with facility personnel and review of facility policy, the facility failed to ensure that Patient #12's boney prominence was assessed on admission and prior to applying a dressing and/or that a comprehensive care plan was developed to include the problem of skin integrity with interventions. The findings include:

a. Patient #12 was admitted to the facility on 3/10/08 following diagnoses of a right fractured hip. Review of the Nursing Admission Assessment dated 3/10/08, identified an assessment of the patient's skin that identified the patient had no pressure areas or abrasions. The Braden Scale completed on 3/10/08, identified that Patient #12 was "at risk" with a score of 17. Review of nursing documentation dated 3/10/08 through 3/11/08 at 4 PM, identified that Patient #12's skin appearance was "within normal limits". On 3/12/08 at 12:21 AM, nursing documentation identified that Patient #12 had a "wound" to the mid-spine to which a duoderm had been applied. Documentation failed to identify the size and stage of the wound. During observation of care on 3/12/08 at 11:25 AM, the patient was observed lying on an air mattress overlay. The boney spinal prominence, with the duoderm removed, was measured at the surveyor's request. An open area, measuring 1 cm x .25 cm, was observed surrounded by deeply reddened tissue. During interview with Hospitalist #1, the patient's attending physician on 3/12/08, he identified that when he saw the patient on admission, Patient #12 was observed to have a reddened, boney protrusion of the spine (lower thoracic/upper lumbar region). The physician stated it was

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reddened and "scabby". Review of Patient #12's care plan on 3/12/08, failed to identify interventions for prevention of skin breakdown and/or interventions for the identified pressure ulcer. Review of the facility policy Skin Integrity Standard directed that documentation for staged ulcers included stage, wound description, measurement of the wound size, drainage, description of the surrounding tissue and treatment planning.

Subsequent to the identification of issues with skin assessments and/or care planning and/or lack of pressure relieving/reducing chair cushions, the facility provided an action plan to address these issues on 3/12/08, which included staff education and immediate ordering of pressure relieving devices for the chair and heels.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

* 16. Based on a review of the clinical records, review of policies, and staff interviews, the facility failed to ensure that a Registered Nurse conducted comprehensive skin assessments for three (3) patients (Patient #15, #16, and #18) on the Senior Behavioral Health Unit. The findings include the following:

a. Patient #15 was admitted to the Senior Behavioral Unit on 3/5/08 with diagnoses that included dementia with behavioral disturbance. Review of the clinical record dated 3/5/08 reflected that LPN #1 completed the admission skin assessment that identified the patient had a reddened buttocks. Review of the clinical record lacked documentation that LPN #1 conveyed this information to a Registered Nurse (RN) therefore, an in-depth assessment of the Patient's skin was not performed.
b. Patient #16 was admitted to the Senior Behavioral Unit on 2/27/08 with diagnoses that included dementia with behavioral disturbance. Review of the clinical record dated 2/27/08 reflected that LPN #1 completed the admission Braden skin assessment that identified the Patient was at moderate risk for the development of pressure ulcers. Review of the clinical record lacked documentation that LPN #1 conveyed this information to a RN, therefore, an in-depth assessment of the patient's skin was not performed.
c. Patient #18 was admitted to the Senior Behavioral Health Unit on 3/5/08 with diagnoses that included dementia with depression. Review of the clinical record dated 3/5/08 reflected that LPN #1 completed the admission Braden skin assessment that identified the Patient was at high risk for the development of pressure ulcers. Review of the clinical record lacked documentation that LPN #1 conveyed this information to a RN, therefore, an in-depth assessment of the patient's skin was not performed. Interview with the Nurse Manager (on 3/13/08) identified that she was unaware that an LPN could not conduct an assessment of the patient's skin.

According to the General Statutes of Connecticut, Volume 7 (revised 1/05), Section 20-87a of the Nurse Practice Act, directs the practice of nursing by a licensed practical nurse is defined as the performing of selected tasks and sharing of responsibility under the direction of a registered nurse or an advanced practice registered nurse and within the framework of supportive and

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restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician of dentist.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (i) General (6).

* 17. Based on observations, review of clinical records, reviews of facility policies and staff interviews, the facility failed to ensure that a Registered Nurse assessed, supervised and/or evaluated the care of four (4) patient's (Patient's #15, 16, 17, and 18) who were at risk for and/or developed stage-one pressure ulcers. In addition, the facility failed to provide pressure-redistributing mattresses and/or chair cushion surfaces for patients at risk for the development of pressure ulcers and/or for patients with identified skin impairment in accordance with hospital policy. The findings include the following:

a. Patient #15 was admitted to the Senior Behavioral Health Unit on 3/5/08 with diagnoses that included dementia with behavioral disturbance. Review of the admission nursing assessment (3/5/08) identified that the patient had a reddened buttocks with a Braden skin assessment that identified the patient was not at risk for the development of pressure ulcers. Although review of the clinical record during the period of 3/5/08 through 3/11/08 identified that the Patient was confused, required assistance with activities of daily living, transfers, had episodes of urinary incontinence, and had a reddened buttocks, the record lacked documentation of care provided to the patient including but not limited to toileting and/or incontinent care and/or repositioning at a minimum of every two (2) hours in accordance with the Standards of Nursing care. On 3/11/08, the patient was observed seated in a wheelchair during the period of 10:45 am to 2:40 pm without the benefit of a pressure-relieving device. At 2:40 pm, during care, the patient was observed to require maximal assistance with toileting and was observed with the Nurse Manager to have a reddened buttocks. Review of the clinical record and interview with the Nurse Manager failed to identify that the initial assessment of the patient's buttocks on 3/5/08 was comprehensive to include a description, staging, size of the wound and/or a treatment plan to address the Patient's reddened buttocks. Subsequent to surveyor inquiry, the Nurse Manager evaluated the Patient, documented the presence of a stage-one (1) pressure ulcer located on the gluteus with implementation of a treatment plan to address impaired skin integrity. In addition, review of the clinical record failed to identify that subsequent Braden Skin assessments were completed on 3/7/08 and 3/9/08. Review of the hospital's Skin Integrity policy directed that Braden skin assessments be completed every 48-hours on the day shift. Interview with the Nurse Manager stated she was unaware that Braden skin assessments were required every 48-hours.
b. Patient #16 was admitted to the Senior Behavioral Health Unit on 2/27/08 with diagnoses that included dementia with behavioral disturbance. Review of the admission nursing assessment dated 2/27/08 identified that the patient was at moderate risk for the development of pressure ulcers. Review of the record during the period of 2/28/08 through 3/11/08 identified that the patient required assistance with ADL's, transfers, had episodes of urinary incontinence and was confused. On 3/11/08, the patient was observed seated in a wheelchair during the period of

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10:45 am to 2:30 pm without the benefit of a pressure-relieving device. At 2:30 pm, during care, the patient was observed to require maximal assistance with toileting, was incontinent of a moderate amount of urine and had a reddened buttocks. Interview with staff working on the Unit (RN #3, RN #4 and NA #1) failed to identify that the patient was provided care during the period of 8:00 am until 2:30 pm (6 1/2 hours). NA #1 stated that although she offered to take the patient to the bathroom at 12:30 pm, the patient refused and she did not check the patient for incontinence. Review of the clinical record with the Nurse Manager identified that the patient's reddened buttocks was new when compared to previous nursing assessments. Although review of the hospital's Skin Integrity policy directed that patient's at risk for the development of pressure ulcers would be turned every-two hours, use pillows for positioning, pressure reduction support surfaces, maximal remobilization, protect heels and manage moisture, nutrition, friction, and shear, review of the clinical record with the Nurse Manager during the period of 2/27/08 to 3/11/08 failed to identify that the patient was provided with this care. Subsequent to inquiry, the Nurse Manager initiated a treatment plan that included incontinent care every two-hours, implementation of pressure-reduction devices, frequent position changes and Braden skin assessments every-48 hours. In addition, further review of the clinical record lacked Braden skin assessments every 48-hours in accordance with hospital policy.

c. Patient #17 was admitted to the Senior Behavioral Health Unit on 3/8/08 with diagnoses that included Dementia with Behavioral disturbance. Review of the initial Braden skin assessment dated 3/8/08 identified that the patient was at low risk (score of 16) for the development of pressure ulcers, however, the assessment was inaccurate in that the patient should have been identified as a moderate risk for pressure ulcers based on additional risk factors (advanced age). Review of the clinical record during the period of 3/8/08 through 3/11/08 identified that the patient was confused, required assistance with ADL's and transfers. During observations on 3/11/08, the patient was seated in a wheelchair without the benefit of a pressure-relieving device from 10:20 am to 1:45 pm. At 1:45 pm, the patient was transferred to the toilet with maximal assistance and the patient was observed to be wearing an incontinent brief saturated with urine down through to the patient's pants. The patient was subsequently provided a shower by staff. Interview with staff working on the Unit (RN #3, RN #4 and NA #1) on 3/11/08 failed to identify that the patient was provided care during the period of 8:00 am until 1:45 pm (5 and 3/4 hours). NA #1 stated that the patient informed her she was dry at 11:30 pm and had not checked the patient for incontinence. Observation of the patient's skin on 3/11/08 at 2:00 pm with RN #3 and the Nurse Manager identified that the patient's coccyx had a 1 centimeter (cm) by 1.5 cm stage-one pressure ulcer, the left outer ankle had a 0.5 cm by 0.5 cm calloused area (not-staged), the left lateral heel had a 2.5 cm by 1 cm stage-one pressure ulcer, and the right heel had a 1.5 cm by 1.25 cm stage-one pressure ulcer with a perimeter redness that measured 5.5 cm by 6 cm. Review of the clinical record with the Nurse Manager identified that these stage one (1) pressure areas were new when compared to previous assessments. Review of the clinical record failed to identify that the patient was provided with incontinent care and/or repositioning every two-hours during the period 3/8/08 to 3/11/08. Subsequent to surveyor inquiry, the Nurse Manager initiated a plan of care to meet the individualized needs of the patient. Interview with the Nurse Manager on 3/11/08 identified that documentation of bowel/bladder status and/or care

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provided to the patient such as incontinent care and repositioning were not captured on the flow record. In addition, review of the clinical record failed to identify that a Braden skin assessment was completed on 3/10/08.

Patient #18, a patient on the Senior Behavioral Health Unit, was admitted on 3/5/08 with diagnoses that included dementia with depression. Although review of the initial Braden skin assessment dated 3/5/08 identified that the patient was at high risk for the development of pressure ulcers, hospital staff failed to implement a treatment plan (preventative measures) in accordance with the Skin Integrity policy. Further review of the record during the period of 3/5/08 through 3/11/08 identified that the patient was confused, required assistance with ADL's and transfers, was incontinent of bowel and bladder and diagnosed with a C-Diff infection on 3/8/08. On 3/11/08, the patient was observed seated in a reclining chair during the period of 10:20 am to 1:30 pm without the benefit of a pressure-relieving device. At 11:30 am, during care although the patient was observed by RN #3 to have a reddened coccyx, a pressure-relieving device for the patient's chair was not provided. At 1:30 pm during care, the patient's coccyx remained reddened and in addition the patient had reddened heels. RN #3 stated that the patient would remain in bed then proceeded to apply a sheepskin heel protector to the patient's left heel. Subsequent to surveyor inquiry on 3/11/08, the Nurse Manager assessed the patient and documented the presence of a stage-one pressure ulcer on the patient's coccyx that measured 0.5 cm by 0.5 cm with bilateral heel redness and initiated a plan of care to meet the individualized needs of the patient. Review of the clinical record failed to identify that the patient was provided with incontinent care and/or repositioning every two-hours during the period 3/5/08 to 3/11/08. In addition, review of the clinical record failed to identify that Braden skin assessments were completed on 3/7/08 and 3/9/08.

Review of facility documentation and interview with the Nurse Manager on 3/13/08 identified that although staff received education regarding pressure ulcer prevention in February 2008, staff were unable to consistently demonstrate knowledge regarding the prevention of pressure ulcer development and/or initiation of the hospital's skin integrity policy.

During a tour of the Senior Behavioral Health Unit (twelve bed unit) on 3/11/08 the surveyor observed "green mattresses" on all patient beds with the exception of one (Patient #18). Interview with the Nurse Manager and VP of Nursing on 3/11/08 stated that they were unable to identify whether these green mattresses provided pressure-relief as the manufacturer could not provide specifications for this mattress type. Subsequent to inquiry, all green mattresses were removed from the Unit and replaced with Versacare beds, a mattress that provided pressure-relief.

Further interview with the VP of Nurses and the Chief Executive Officer on 3/11/08, identified that the hospital did not have pressure relieving chair cushions in the facility. Subsequent to the identification of issues with skin assessments and/or care planning and/or lack of pressure relieving/reducing chair cushions, the facility provided an action plan to address these issues on 3/12/08, which included staff education and immediate ordering of pressure relieving devices

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for the chair and heels.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (e) Nursing service (1) and/or (i) General (6) and/or (l) Infection Control (1)(A).

18. Based on observation of patient care, review of the clinical record, review of hospital policies and interviews with staff, the hospital failed to ensure that infection control practices were implemented. The findings include the following:

a. Patient #18 was admitted to Senior Behavioral Health Unit on 3/5/08. Review of the clinical record dated 3/8/08 identified that the patient developed a C-Diff infection with contact precautions initiated. During observation of care on 3/11/08 at 1:30 pm with the Nurse Manager, RN #3 and RN #4 were observed to don gowns and gloves and assisted the patient into bed. Patient #18 was noted to be incontinent of a medium loose stool. During incontinent care, RN #4 was observed to cleanse the patient from front to back then utilizing the same soiled cloth, continued to provide incontinent care cleansing from back to front. RN #4 was observed to touch the footboard of the patient's bed with soiled gloves, removed the soiled gloves and tossed the gloves onto the patient's bed. RN #4 then reached beneath the isolation gown and into his pocket for gloves. RN #4 donned new gloves without the benefit of handwashing and continued to provide care to the patient. Interview with the Nurse Manager identified that RN #4 would be immediately educated regarding infection control practices and proper perineal care.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (1) and/or (2) and/or (c) Medical staff (2) and/or (d) Medical records (3) and/or (e) Nursing service (1) and/or (g) Pharmacy (1) and/or (2) and/or (i) General (6).

* 19. Based on a review of clinical records, review of hospital policies and/or protocols, and interviews with staff, the facility failed to ensure that Departments within the hospital (Medicine, Nursing and Pharmacy) were accountable for safe and effective ordering, distribution and administration of medications for two sampled patients (Patient #9 and #25) who required intravenous titration of medications. As a result, patients received medications, which were titrated without specific physician orders. In addition, for the same two Patients's, nursing failed to reassess the patient subsequent to titration of medication to determine efficacy and/or when a change in the patient's vital signs were identified. The findings include the following:

a.Patient #9 was admitted to the ICU on 2/4/08 with acute respiratory failure and was subsequently placed on a ventilator. Review of a physician's order dated 2/4/08 at 12:00 am directed that Propofol (general anesthetic) 10 micrograms (mcg) be administered intravenously (IV) every two (2) to five (5) minutes (bolus dose) until the target VAMASS (Ventilator Adjusted Motor Assessment Scoring Scale) level was achieved. The order further directed that a continuous Propofol infusion be initiated at five (5) micrograms (mcg) per kilogram (kg) per minute and titrate infusion to maintain target

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VAMASS by 5-10 mcg/kg/min every 5-10 minutes. The VAMASS goal determined by the physician was 1A (opens eyes and/or moves to pain only, minimal coughing, few alarms when stimulated, settles to voice or removal of stimulus). Review of the clinical record with the Nurse Manager identified that although the physician's order directed Propofol be administered as a bolus at 10 mcg/kg every 2-5 minutes until target VAMASS is achieved, the record lacked documentation that the Propofol bolus was administered. In addition, review of the record identified that the RN initiated a continuous Propofol drip at 6 mcg/kg/min although the physician's order directed Propofol 5 mcg/kg/min. Interview with the Nurse Manager identified that the RN failed initiate the Propofol drip in accordance with physician's orders.

In addition, Patient #9's clinical record identified that a continuous Propofol drip at 6 mcg/kg/min was initiated on 2/4/08 at 2:00 am with a VAMASS level of 2A (opens eyes, moves to voice, coughing, frequent alarms when stimulated and settles to voice or removal of stimulus). The VAMASS goal ordered by the physician was 1A (opens eyes and/or moves to pain only, minimal coughing, few alarms when stimulated, settles to voice or removal of stimulus). Review of the clinical record identified that although the Propofol drip was initiated at 2:00 am (on 2/4/08), the patient had increased VAMASS scores of "2A" at 2:00 am, 3:00 am, 4:00 am, 5:00 am, and 6:00 am. The RN failed to follow the physician's order that directed the Propofol be titrated by 5-10 mcg/kg/min every five minutes to achieve a VAMASS level of 1A. Interview with the Nurse Manager stated that the RN should have increased the Propofol drip based on the physician's order until the prescribed VAMASS goal of 1A was achieved.

In addition, review of Patient #9's clinical record identified that although the RN increased the patient's Propofol drip from 6 mcg/kg/min to 7.2 mcg/kg/min at 3:30 am and from 7.2 mcg/kg/min to 11.54 mcg/kg/min at 5:45 am, the patient maintained a VAMASS level of 2A and never achieved the goal of 1A as prescribed by the physician. Interview with the Nurse Manager stated that the RN should have reassessed the patient within 5-10 minutes of the medication change to determine efficacy and continue to follow the titration orders until the prescribed VAMASS goal of 1A was achieved. Review of the physician's order for IV Propofol with the Nurse Manager failed to identify dose increments for titration (increasing and/or decreasing the dose) and/or a maximum dose. The Nurse Manager identified that the RN determines dose increments within the 5-10 mcg parameter range as directed in the physician's order and stated that the Propofol order didn't indicate a maximum dose but identified a usual range (5-50 mcg/kg/min).

In addition, Patient #9 had a physician's order dated 2/4/08 at 12:00 am that directed "Propofol vacation every 8:00 am" to assess the patient's neurological status, weaning status, and pain scale but lacked specific titration parameters for weaning the patient off the medication (increment and frequency). Review of the clinical record with the Nurse Manager identified that on 2/4/08 at 8:45 am, the patient's continuous Propofol infusion running at 11.54 mcg/kg/min was turned off for "Propofol Vacation". The clinical record lacked documentation that described how the Propofol was titrated and/or the patient's response to stopping the medication during the period of 8:40 am through 8:54 am. At 8:54 am, the clinical record indicted that the Propofol drip was restarted at 10

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mcg/kg/min.

In addition, Patient #9's clinical record dated 2/4/08 identified that the patient was maintained on the Propofol drip at 15 mcg/kg/min from 9:42 am through 1:10 pm. A physician's order at 1:15 pm directed that the continuous Propofol infusion be discontinued. Although review of the clinical record identified that the Propofol drip was discontinued at 1:10 pm, the physician's orders failed to specify how the medication would be decreased and the time frame for discontinuing the medication. Review of the Propofol policy with the Nurse Manager failed to identify titration parameters for discontinuation of this medication.

Interview with the Nurse Manager on 3/18/08 identified that in February 2007, a new policy for Propofol administration was presented to the hospital's Clinical Practice Committee where the policy was approved. The Nurse Manager stated that she educated ICU nurse's regarding the new Propofol policy and procedure in April 2007. Review of the education presented to staff identified that the Propofol Bolus be initiated at 10 mg IV until target VAMASS is achieved and is immediately followed by a continuous infusion of Propofol with instructions for initiation of the continuous drip (increase by 5-10 mcg/kg/min until desired effect). The education further identified that Propofol should not be abruptly discontinued. Review of the Propofol policy and procedure (issued 4/07) failed to identify specific parameters for increasing and/or decreasing the medication, frequency of titration, guidance for Propofol vacation, and/or maximum dosages.

b. Patient #25 was admitted to the ICU on 12/17/07 with a diagnosis of exacerbation of COPD. Review of a physician's orders dated 12/17/07 directed a continuous IV infusion of Dobutamine (Inotrope) at 5 mcg/kg/min and titrate to maintain a systolic blood pressure (B/P) greater than 85 millimeters of mercury (mmHg). Review of the clinical record identified that the Dobutamine was started at 12:50 pm with a documented B/P of 80/50. Review of the flow record with the Nurse Manager identified that the Dobutamine rate was titrated (increased and decreased) during the period of 8:40 pm (on 12/17/07) through 3:51 am (on 12/18/08) without specific physician's orders for titration. Review of the hospital protocol for IV Dobutamine with the Nurse Manager failed to identify dose increments for titration (increasing and/or decreasing the dose) and/or a maximum dose. The Nurse Manager identified the RN decided dose increments based on the Standard IV Drip protocol that reflected average rate and dosage ranges and lacked a maximum dosage for this medication.

In addition, review of the clinical record dated 12/17/07 at 5:32 pm identified that Patient #25 was maintained on a Dobutamine IV drip at 5 mcg/kg/min with an order to titrate the drip to maintain a systolic B/P greater than 85 mmHg. Although the patient had a documented B/P of 82/50 at 6:02 pm, staff failed to intervene until 8:40 pm (one hour and 38 minutes later) when the Dobutamine IV drip was increased from 5 mcg/kg/min to 6 mcg/kg/min based on a B/P of 70/30. Review of the Physical Assessment policy with the Nurse Manager identified that if a patient is receiving IV vasoactive medication, document the B/P every five (5) minutes until stable then on an hourly basis.

In addition, although Patient #25 had a documented B/P of 71/25 at 9:00 pm, staff failed to reassess the

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patient until 9:28 pm (28 minutes later) when the B/P was noted to be 76/30 and the RN increased the Dobutamine IV drip from 6 to 7.5 mcg/kg/min. Further review of the record with the Nurse Manager identified that although the patient's B/P was below the prescribed maintenance goal of 85 mmHg (systolic), the patient was not assessed until 12:00 am on 12/18/07 (2 ½ hours later) with a documented B/P of 82/43. At 12:00 am (on 12/18/07), the RN increased the Dobutamine IV drip from 7.5 to 9 mcg/kg/min, however failed to reassess the patient until 3:30 am (3 ½ hours later). The RN failed to reassess the patient subsequent to titration of the medication to determine tolerance and/or efficacy of the change in dosage. According to the Lippincott (Williams & Wilkins) Drug Handbook, 26th Edition, Dobutamine IV has an onset of 1-2 minutes and peaks within 10 minutes of infusion. Interview with the Nurse Manager identified that the patient's B/P was not maintained at a systolic rate greater than 85 mmHg in accordance with physician orders.

In addition, Patient #25 had a physician order (time of order not specified) dated 12/18/07 that directed the Dobutamine IV drip be discontinued. Review of the clinical record with the Nurse Manager failed to identify titration orders to discontinue the drip and/or failed to indicate when the drip was discontinued.

Further review of policies and/or procedures of IV medications that may be titrated by physician's orders (Sedative/Hypnotics, Antiarrhythmics, Vasodilators, Vasopressors/Inotropes and Opioids) lacked specific instructions for ensuring safe administration of these medications.

Interview with Pharmacist #1 on 3/13/08 identified that physician's handwrite orders which are then faxed to the pharmacy for verification. Pharmacist #1 identified that Propofol and Dobutamine required specific physician orders and had associated protocols. Pharmacist #1 could not recall any issues and/or concerns relative to titratable medications.

Interview with the Interim Director of Pharmacy on 3/18/08 identified that in addition to pharmacist verification prior to dispensing of medication, pharmacists print medication profiles daily and are expected to review each new order against the Medication Administration Record in the patient unit, however, identified that this task is work dependent and not always done.

Interview with the CEO and VP of Nursing on 3/18/08 identified that they were unaware of any concerns related to the titration of intravenous medications and stated that although there is not an official Medical Director in the ICU, the Hospitalists provided oversight of the Unit. Review of the Medical Staff Bylaws, Rules And Regulations identified that the attending physician would be responsible for the preparation of a complete medical record including therapeutic orders.

Subsequently, on 3/18/08, the Department requested an Immediate Action Plan. The facility initiated this Action plan on 3/18/08 and included communication to all staff affected, developed protocols for titratable medications that included all elements of a physician's order (name of drug, starting dose, maximum dose, parameters of drug, titration by increment, limits and reason for maintenance of the drug) and audits of patient's on titrated medication.

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22. Based on surveyor review of the Blood Bank procedure manual and maintenance records for 2006 through 2008 and interview with the acting supervisor, it was determined that the laboratory failed to perform and document the calibration of the serofuge, used to perform patient antibody screens and donor blood unit crossmatches, since the third quarter of 2006 when the supervisor left on medical leave.

The findings include:

A review of the Blood Bank procedure manual on March 18, 2008 revealed that calibration was performed and recorded on July 26, 2006, in accordance with the laboratory's written procedures. However, the equipment maintenance manual did not include a maintenance schedule for serofuge calibration. An interview with the acting supervisor on March 18, 2008 at 1 PM revealed that she did not see the serofuge calibration procedure in the procedure manual, and was not aware that the serofuge needed to be calibrated.